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MEDICAID MEMO

TO: All Acute/General and Rehabilitation Hospital Providers and MCOs Participating in the Virginia Medical Assistance Programs

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

MEMO: Special

DATE: 4/2/2008

SUBJECT: New National Drug Code (NDC) Billing Requirement for Pharmacy Claims Submissions (UB04/837I) – Effective July 1, 2008

To comply with the Centers for Medicare and Medicaid Services' (CMS) requirements related to the Deficit Reduction Act (DRA) of 2005, a change involving all drugs administered in an outpatient hospital setting will become effective with dates of service on and after **July 1, 2008.** The Department of Medical Assistance Services (DMAS) will require hospital providers who bill drug products administered in an **outpatient hospital setting** to include National Drug Code (NDC) information of the drug dispensed on all electronic (ASC X12N Health Care Claim: Institutional 837I) and paper claim (Universal Billing (UB) form) submissions.

Collaborative Efforts with Virginia Hospitals

This federal mandate was to have been effective January 1, 2008 as mandated by the DRA of 2005. Starting in mid November 2007, DMAS started discussions with a workgroup of Virginia hospitals on this requirement for submitting NDC numbers on the Institutional paper and electronic claims. Due to the hardship that this requirement would impose on Virginia hospitals, DMAS sent a letter to CMS on December 12, 2007 requesting an extension of this mandate for eighteen months, which the Virginia Hospital and Health Care Association reviewed. The letter cited the costs, systems, and vendor issues that were identified by the hospital workgroup. However, after reviewing our proposal, CMS would only grant a six month extension to July 1, 2008. To date, continued efforts by DMAS to negotiate a more favorable extension were not successful. Subsequently, DMAS has and will continue its discussions with the hospital workgroup to review the technical specifications contained in this Medicaid Memorandum, and to implement this federally-mandated requirement in the most effective manner.

NDC Changes Effective July 1, 2008

National Drug Code (NDC)
Effective July 1, 2008, hospital providers who administer drug products in **outpatient hospital settings** will be required to include valid NDCs on claims submissions. A valid NDC is defined as a correctly formatted number using the 5-4-2 format, i.e., 5-digits, followed by 4-digits, followed by 2-digits (99999888877). Each NDC must be an **11-digit code** unique to the manufacturer of the specific drug or product administered to the recipient. If the provider is billing for a compound medication with more than one NDC included in the medication dispensed, each applicable NDC must be submitted as a separate claim line to include both prescription and over-the-counter ingredients. Outpatient hospital claims submitted without a valid NDC will have the revenue code line reduced to a non–covered service line.

Billing Requirements

DMAS will deny paper or electronic 837I claims with pharmacy charges if the proper billing requirements are not followed. The billing requirements are defined below as they pertain to the paper and electronic formats.

Submitting NDC-Related Data via the Paper Claim Form (UB04)
Effective July 1, 2008, drugs received on the UB04 CMS 1450 or Medicare crossover with any **pharmacy indicated revenue code(s)** MUST have Form Locator 43 (description) completed with the corresponding 11-digit NDC number, followed by the Unit of Measurement Qualifier, then the NDC Unit Quantity; otherwise, the claim will be reduced as a non-covered service line. The N4 modifier is the first indicator in this locator and MUST be followed by all the required information (NDC, unit of measurement qualifier, and the NDC unit quantity). If the same medication is dispensed in different package sizes, each package size MUST be listed separately using the revenue code, N4 qualifier and all required information on separate lines. Different package sizes of the same drug will NOT be viewed as duplicate claims (same revenue codes on different lines) by the system.
If available, enter **Locator 44 (HCPCS/Rate/HIPPS Code) HCPCS code** and **Locator 46 (Serv Unit), HCPCS units**. DMAS will **validate all HCPCS codes**; if the HCPCS code is **not** valid, DMAS will **deny** the claim.

DMAS will monitor and edit all outpatient hospital claims to ensure that the pharmacy revenue codes are submitted with an NDC. Claims submitted without the NDC will be reduced. Each claim (line) submitted with an N4 qualifier MUST have the associated NDC and revenue code billed on that line. This is especially important for revenue codes 0250 through 0259 and 0630 through 0639.

Locator 42 (Rev CD.)
Enter the Revenue code

Locator 43 (Description):

When billing for a drug, you must enter the NDC qualifier of N4, followed by the 11-digit NDC number, and the unit of measurement followed by the metric decimal quantity or unit. Do not enter a space between the qualifier and NDC. Do not enter hyphens or spaces within the NDC number. The

NDC number being submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered.

Example of Locator 43: Modifier, NDC, Unit of Measurement Qualifier and the NDC unit of measurer:

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	3	4	.	5	6	7	
1.		2.											3.		4.								5.

1. Report the N4 qualifier in the first two (2) positions, left-justified.
2. Immediately following the N4, specify the 11 character NDC number in the 5-4-2 format (no hyphens).
3. Immediately following the last digit of the NDC (no delimiter) provide the Unit of Measurement Qualifier. The Unit of Measurement Qualifier codes are as follows:
   F2 – International Units
   GR – Gram
   ML – Milliliter
   UN – Unit
4. Immediately following the Unit of Measurement Qualifier, enter the numeric quantity administered to the patient. Enter the actual metric decimal quantity (units) administered to the patient including decimals.

   Examples of NDC quantities for various dosage forms as follows:
   a. Tablets/Capsules – bill per UN
   b. Oral Liquids – bill per ML
   c. Reconstituted (or liquids) injections – bill per ML
   d. Non-reconstituted injections (i.e. vial of Rocephin powder) – bill as UN (1 vial=1 unit)
   e. Creams, ointments topical powders – bill per GR
   f. Inhalers – bill per GR

5. Any spaces unused for the quantity should be left blank.

Locator 44 (HCPCS/Rate/HIPPS CODE)
Enter the HCPCS code **if available. Invalid HCPCS codes will deny.**

Locator 46 (Serv Units)
Enter the HCPCS units when a HCPCS code is in locator 46

Please refer to the completed UB04 CMS 1450 claim example on the next page.

1 Facility	2 Facility	3a. PAT. CNTL#	123456789	4 TYPE OF BILL
123 Main Street Somewhere Va 66666-0000 785-555-5555 785-555-5555	PO Box 1234 Somewhere Va 66666-0000	b. MED REC#	987654321	
		5 FED.TAX NO.	48-5555555	6 STATEMENT COVERS PERIOD FROM 060107 THROUGH 061007
				7

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 123 North 12th Street
b Smith Joseph R	b Somewhere c VA d 66666-0000 e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30
01011911	M	060107								

31 CODE	OCCURRENCE DATE	32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE FROM	THROUGH	36 CODE	OCCURRENCE FROM	THROUGH	37

38	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	a					
	b					
	c					
	d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HIPPS Code	45 SERV. DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250	N412345678901UN1234.567	J1234		10	$100	*	**
0250	N412345678901	J1234		1	$100	Cut Back*	
0362	N412345678901UN1234.567			1	$100		
0263	N412345678901	S0077		4	$100	Cut Back*	
0263		S0077		4	$100		**
0250	N412345678901			10	$100	Cut Back*	
NOTE:	Lines 1, 3 and 5 are payable Lines 2.4. and 6 are non covered						
	*If the NDC is invalid- the line will be cut back.						
	**If the HCPCS code is invalid- the claim will deny						
	PAGE _____ of _____	CREATION DATE		TOTALS ⇨			

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1234567890
						57	
						OTHER	
						PRV ID	

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Joseph Smith	18	555555555A		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX			B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

Converting NDCs from 10-digits to 11-digits

It should be noted that many NDCs are displayed on drug packaging in a 10-digit format. Proper billing of an NDC requires an **11-digit** number in a 5-4-2 format. Converting NDCs from a 10-digit to 11-digit format requires a strategically placed zero, dependent upon the 10-digit format. The following table shows common 10-digit NDC formats indicated on packaging and the associated conversion to an 11-digit format, using the proper placement of a zero. The correctly formatted, additional "0" is in a **bold font** in the following examples. Note that hyphens indicated below are used solely to illustrate the various formatting examples for NDCs. Do not use hyphens when entering the actual data on your claim. DMAS recommends that providers consult with their pharmacy staff or supplier to clearly understand the conversion of 10-digit to the 11-digit format.

Converting NDCs from 10-digits to 11-digits					
10-Digit Format on Package	**10-Digit Format Example**	**11-Digit Format**	**11-Digit Format Example**	**Actual 10-Digit NDC Example**	**11-Digit Conversion of Example**
4-4-2	9999-9999-99	5-4-2	**0**9999-9999-99	0002-7597-01 Zyprexa® 10mg Vial	**0**0002-7597-01
5-3-2	99999-999-99	5-4-2	99999-**0**999-99	50242-040-62 Xolair® 150mg vial	50242-**0**040-62
5-4-1	99999-9999-9	5-4-2	99999-9999-**0**9	60575-4112-1 Synagis® 50mg vial	60575-4112-**0**1

Submitting NDC-Related Data via the 837 Institutional Claim Format (ASC X12 837I V4010 A1)

Loop 2400 – Procedure Code and Units

The procedure code is defined in the 2400 loop, segment **SV2**, composite data element **SV202**. No NDCs should be sent in this segment. SV202 must contain the appropriate HCPCS code if one exists. Data element **SV204** defines the Unit or Basis of Measurement Code. The units must be defined as Unit, Days, or International Unit (International Unit is used to indicate dosage amount; dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number). Data element **SV205** of loop 2400 defines the quantity based on the Basis of Measurement in SV204.

Loop 2410 – Drug Identification

The NDC should be sent in the 2410 loop LIN segment of the 837I transaction. The 2410 loop can be repeated 25 times within a service line. Virginia Medicaid will capture only the first occurrence of the LIN segment for each revenue line. If billing for a compound medication with more than one NDC, then each applicable NDC must be sent as a separate revenue line.

LIN - This segment identifies the NDC. Data element **LIN02** must contain the qualifier N4 and data element **LIN03** must contain the National Drug Code in the 5-4-2- format.

CTP – This segment identifies the drug pricing. Elements within this segment are:

- **CTP03-** Drug Unit price (DMAS will not be validating nor use this segment of the Loop 2410. This is however a required segment based on the 837I guides but provider will have to enter an amount. DMAS will recognize $0.00 as an amount.)
- **CTP04 -** Quantity
- **CTP05 -**Composite unit of measure
- **CPT05-1** defines the Unit or basis for measurement code.
  Note: Refer to the 837I Implementation Guide for valid values
  (F2 – International Unit, GR – Gram, ML – Milliliter, UN – Unit).

The note from the 837 I Implementation Guide states that the CTP segment is "Required when it is necessary to provide a price specific to the NDC provided in LIN03 that is different than the price reported in SV203 (for 837I)".

Example EDI segments:

1. With HCPCS Code and the NDC (this line would be cut back)

LX*1~
SV2*0259*HC|J7515*16.8*UN*2~
DTP*472*D8*20071029~
LIN**N4*00172731046~

2. Without HCPCS Code and with the NDC and pricing

LX*1~
SV2*0259**16.8*UN*2~
DTP*472*D8*20071029~
LIN**N4*00172731046~
CTP***1.23*2*UN~

3. With HCPCS Code and with the NDC and pricing LX*1~

SV2*0259*HC|J7515*16.8*UN*2~
DTP*472*D8*20071029~
LIN**N4*00172731046~
CTP***1.23*2*UN~

Please discuss necessary changes with your technical staff or resource. The most recent version of the 837I Companion Guide is located at https://virginia.fhsc.com/hipaa/CcompanionGuides.asp.

SYSTEMS TESTING

Hospital providers, who have expressed interest in testing their systems, may contact Bonnie Winn at 804-786-2621 or at bonnie.winn@dmas.virginia.gov, for paper claims testing and for electronic claims, contact the EDI Technical Help Desk at 800-924-6741.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include upcoming changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr-enewsletter.asp.

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